Facilitated Communication: Can we talk about it?

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Workshop presented by Bethesda Outreach Services, St Catharine's Ontario

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Topical Outline
May 29, 1998

- Introduction (Forgeron)
- FC, what is it? (Biklen's 25 features and an update) (Duchan)
- Issues of validity (Duchan)
- Cautionary practices (Duchan)
- Break
- Bethesda experiences (Forgeron)
- Questionnaire (Forgeron)
- Discussion (Everyone)

Twenty Five Features of Facilitated Communication

(Duchan's adaptation of Biklen, 1990, 1993)
May 29, 1998

Emotional (Attitudinal) Support:

1. Don't patronize the communicator with nervous jokes, excessive familiarity, or babying. Be candid.
2. Be reasonably vulnerable and self-effacing.
3. Be apologetic about the assessment process.
4. Don't dominate.
5. Don't use labels to identify student's disability.
6. Assume the person's competence.
7. Believe communication is important.
8. Help the person avoid errors--provide successful experiences, prompt (pull back or comment) if an error is about to be made
9. Provide encouragement--do not punish for errors made.
10. Provide support to help person stay on task.

Physical Support

11. Create a supportive and stable physical context (attend to seating arrangement, angle of device, relaxed atmosphere)
12. Provide needed physical support to help person move (under forearm, under or above wrist, helping the person isolate index finger)
13. Pull back person's hand or arm after each choice so that the person takes enough time to make the next selection

Communicative Support

14. Regard communication as a process that changes over time. Encourage practice.
15. If the person is not communicating, use structured questions and materials to get started (e.g., fill in blanks)
16. Identify barriers to communication (motor instability that creates typographical errors; occurrence of meaningless repetitions)
17. Ignore stereotypic utterances in oral productions, focus instead on manual typing.
18. Ignore behaviors such as screeches, hand slapping, etc, by asking about the task ("What's the next letter you want?"

Curricular Support

19. Don't test the person by asking questions you know answer to.
20. Give choices.
21. Use interesting materials.
22. Don't start by focusing on feelings; allow person to initiate discussions about feelings.
23. Have groups of people use FC together.

Facilitator Monitoring

24. Monitor person's eye and hand movements (this helps identify and prevent errors and to know when the person is attending to the task)
25. Facilitator needs to do several tasks at once--carry on verbal conversation, watching communicators eyes, looking at output.

FC Can we Talk about it?

Judy Duchan
Bethesda workshop
May 29, 1998

1

The Method's Validity

- Questions related to validity
- Approaches to validation
- Research approaches to validation
- Clinical approaches to validation
- Documenting progress

2

Questions of Validity

- Is FC a valid approach in general?
- Is FC valid for a particular person?
- Is a message produced via FC a valid one? Was it authored by the communicator or the facilitator?
- Is the information in an communicator's message true or accurate?
- Are methods evaluating the approach valid?

3

Approaches to Validation

- Detailed qualitative case studies
- Communicators who no longer need physical support from facilitator
- Significant changes in the behavior of the communicator
- Qualitative indicators of authorship
  - unique spellings and discourse, messages with information unknown to facilitator, proven cases of reported abuse

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- Controlled experimental studies--O.D. Heck

Research Approaches to Validation

- Qualitative studies: Some positive results, especially if given practice and done in natural, motivating settings (see Biklen & Cardinal, 1997, for sample studies and a review).

Experimental studies: Overwhelmingly negative, many show facilitator influence (see Green, 1994; Shane, 1994, and ASHA's Technical Report, 1994, for reviews).

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Clinical Approaches to Validation

- Tracking changes-anecdotal notes
  behavior, communication without FC, communication with FC, communications with different facilitators
- Make note of messages containing unshared information or with unique form or content
- Carry out ongoing validation with different degrees of control

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Cautionary Practices

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- Position statements
- Guidelines
- Informed Consent
- Recommended Practices
- Responding to actionable statements

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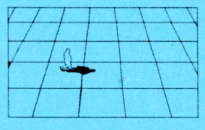
Position Statements



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TASH Resolution 1992

- Describes FC
- Says it is controversial--some studies negative results, some show influence, some positive
- Communicator rights--access to legal council
- importance of training, use of multiple strategies
- appreciation to those who use FC

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ASHA Position Statement, 1995

- Description of FC
- Personal accounts and qualitative description indicate positive results
- Experimental and controlled studies, negative results
- Problem of facilitator influence
- Problem if other approaches supplanted
- Sceintific validity and reliability not been demonstrated.

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ASHA 1995

- Should not make treatment decisions solely based on FC
- Should work toward independence
- Should inform potential users of FC indicating validity and reliability of FC not been established
- Should obtain their consent before using FC
- Each SLP should decide for him or herself whether to use FC

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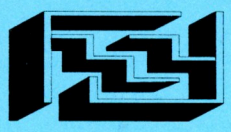
Guidelines



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ASHA Guidelines-Draft

- Description of FC
- FC and AAC
- Informed Consent
- Recommended Practices
- Documentation of Effectivenes
- Responding to Actionable Statements

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Informed Consent

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Informed Consent: ASHA Draft

- FC is an experimental approach
- FC is a technique whose efficacy has not been validated by experimental research
- Why FC is being recommended
- Other approaches available
- Rights of individual to full range of approaches
- Guardians and communicators will be informed and consulted regularly about decisions related to communication

Informed Consent ASHA (Cont)

- FC can be terminated at any time
- Something about potential of facilitator influence
- Communicator and guardians will have access to records
- Sensitive messages will be kept confidential
- Summary of risks and benefits

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Informed Consent

- possible benefits and risks
  - possible enhancement of ability to communicate
  - potential for improved behavior
  - risk of facilitator influence, like for all methods of teaching, efforts must be made to make sure learners can develop in under least restrictive conditions
  - risk of person's overdependence on method, all involved will need to work toward communicator independence

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Recommended Practices

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ASHA Draft

- Indicate details about skills of individual
- Team Approach
- Training of Facilitators
- Ongoing Monitoring
- Physical Independence
- Right to privacy

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Candidacy Considerations

- Hand functioning
- Motor differences
- Different performance with supports:
  - physical
  - communicative
  - contextual
  - technological
- Consideration of a trial period of use

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Assessment Documentation

- Facilitator's skills and supports
- Individual's skills
- Areas:
  - physical
  - communicative
  - contextual
  - technological

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Team approach

- Collaborative teaming is an interactive process that enables teams of people with diverse expertise to generate creative solutions to mutually defined problems. The outcome is enhanced, altered, and produces solutions that are different from those that the individual team members would produce independently.

– Idol, Paolucci-Whitcomb& Nevin, 1986, p1

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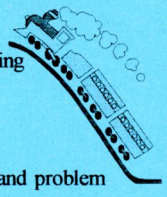
Training



- Observation and hands on training
  - nature of supports
  - skill development over time
- Feedback and supervision
- Strategies for decision making and problem solving with team
- Resource materials and information dissemination
- Ongoing monitoring of skills and knowledge of new insights and research in the field

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Training: ASHA DRAFT--What facilitator competence entails:

- use of multiple facilitators
- know and use of other AAC approaches
- do ongoing documentation and assessment
- knowlatest research and potential for facilitator influence
- can tailor physical support to needs
- can assess hand functioning

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Training ASHA Draft (2)

- have skill in designing communication system and in use of technology
- foster communicator's independence
- provide contexts that value communicator's contributions
- enhance literacy
- provide appropriate emotional support
- monitor and update techniques used in FC

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Responding to Actionable Messages

- Have a plan in place
- Follow standard procedures
- Collect corroborating evidence
- Verify the message

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Facilitated Communication: Yes, we can talk about it

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What needs talking about?

- What it is
- What it would take to consider it valid
- How it compares with other approaches
- Who to use it with
- How to provide best support
- How to avoid excessive influence
- How best to respond to actionable statements

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And, while we're at it, lets talk about our other approaches too!

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RESOLUTION

FACILITATED COMMUNICATION

Facilitated communication (also referred to as facilitated communication training) is an alternative means of expression that has been used by individuals who cannot speak or whose speech is limited and who cannot point reliably. The method involves a communication partner, typically called a facilitator, (e.g. teacher, friend, parent) providing physical and emotional support as the person points at pictures, letters, words, or other symbols.

The method is controversial. In some research studies, individuals using facilitation have not demonstrated that they were able to convey their own thoughts through the method. Some studies have revealed that individuals could be influenced by or pick up on cues from their facilitators. In other studies, individuals have demonstrated the ability to express their own ideas and to do so without influence or cue seeking. Others have progressed from supported to independent typing.

The question of authorship can become particularly controversial when the subject of what has been communicated concerns sensitive issues. Such topics may include, for example, preferences about living arrangements, allegations of abuse, and selection of personal assistants.

THEREFORE BE IT RESOLVED THAT:

1 TASH regards access to alternative means of expression an individual right.*

2 TASH encourages its membership to become informed about the complexities of facilitated communication training and practice and to stay informed of new research and practice throughout the facilitated communication training process.

3 TASH encourages people who decide to become facilitators to seek training in the method.

4 TASH encourages careful, reflective use of facilitated communication.

5a TASH encourages facilitators to work in collaboration with individuals with severe disabilities to find ways of confirming communication competence when using facilitation.

5b To this end, TASH encourages use of multiple strategies, including, for example: controlled designs; portfolio analysis; and transitioning to independent typing.

6 TASH urges that when allegations of abuse or other sensitive communication occur, facilitators and others seek clarification of the communication and work to ensure that users of facilitation are given the same access to legal and other systems that are available to persons without disabilities. It is important not to silence those who could prove their communication competence while using facilitation or any other method of expression.

7 TASH expresses its appreciation to individuals who have disabilities and who have learned to communicate through facilitation and who have been instrumental in discovering ways for themselves and others to demonstrate their communication competence.

* *See the TASH "Resolution on the Right to Communicate" (Adopted, November, 1992), on the page opposite.*

RESOLUTION 1994 DEC ADOPTED

RESOLUTION

THE RIGHT TO COMMUNICATE

In its efforts to be fully supportive of the rights of all people, including those with severe disabilities, TASH has passed two resolutions that state with absolute clarity the organization's position on the right to, and choice of method of communication.

The right to communicate is both a basic human right and the means by which all other rights are realized. All people communicate. In the name of fully realizing the guarantee of individual rights, we must ensure:

- that all people have a means of communication which allows their fullest participation in the wider world;
- that people can communicate using their chosen method; and
- that their communication is heeded by others.

Where people lack an adequate communication system, they deserve to have others try with them to discover and secure an appropriate system. No person should have this right denied because they have been diagnosed as having a particular disability. Access to effective means of communication is a free speech issue.

ACCESS TO COMMUNICATION

All persons born with disabilities should be given therapy and training directed towards permitting them to communicate freely. All people with communication disabilities should be given the full opportunity to use augmentative and alternative communication. 'Access' includes access to assessment to judge the suitability of the method, access to training in the method; and access to any equipment needed, both in the short term during training and in the longer term for continued use on a daily basis if training is successful.

EDUCATION

Education in communication techniques is an essential element of the education of people with communication disabilities. People using augmentative or alternative communication must be given any assistance necessary to use that system in the educational system. Any equipment, training or staffing necessary to enable communication to take place must be supplied, both to that person and to those with whom he or she wishes to interact on a regular basis.

FREEDOM TO COMMUNICATE

No person should be able to veto the use of another person's augmentative *or alternative communication, and in* any instances where such use is forbidden, there should be recourse to the legal and protective systems. People with communication disabilities *must be allowed to use the* communication system of their own choice in all communication interactions in any setting.

LEGAL ISSUES

People using augmentative communication must be permitted to use the system of their own choice in court. Any person using a communication strategy requiring the involvement of another person to receive and relay their communication (e.g. manual sign, communication boards, facilitated communication) must be permitted to use the partner of their choice in court.

PRESUMPTION OF COMPETENCE IN DECISION-MAKING AND ADVOCACY

People are presumed to have an active interest in decisions affecting their lives on a short-term and long-term basis. In planning or decision-making on a person's behalf, that person's participation must be ensured regardless of the formal communication modalities used. This may include the involvement of allies, advocates *and* communication partners before and after meetings, *and may also include the involvement* of a "communication ally" during the course of the meeting.

RESOLUTION ADOPTED 1994 NOV.

Two years ago at the urging of Bob Williams and other Board Members, TASH developed and approved a comprehensive resolution on the right to communicate. That resolution has guided our position and activities surrounding the issue of facilitated communication. Recently, professional associations and public agencies have adopted a statement on facilitated communication (see TASH's October, 1994 *Newsletter* article by Mayor Shevin) which do not take into account, or are at odds with, the right to communicate. In its commitment to be fully supportive of the rights of all people, including those with severe disabilities, TASH has passed a second resolution that states with absolute clarity the organization's position on the right to, and choice of methods of, communication. Both resolutions are reprinted here.

Facilitated Communication

American Speech-Language-Hearing Associaation

This position statement is an official policy of the American Speech-Language-Hearing Association (ASHA). It was developed after select and widespread peer review by ASHA's Speech-Language Pathology Division: Diane Paul-Brown, division director; Louise Zingeser, branch director. Crystal S. Cooper, 1994-1996 vice president for professional practices in speech-language pathology, served as monitoring vice president. The contributions of Stan Dublinske, director, Professional Practices Department, and Kelley Turnbull, departmental assistant, Professional Practices Department, are gratefully acknowledged. The Legislative Council adopted this statement in November 1994 (LC 51-94). For additional information, please refer to the Technical Report on Facilitated Communication (Facilitated Communication Subcommittee of the Ad Hoc Committee on Auditory Integration Training and Facilitated Communication, 1994, October).

Facilitated Communication is a technique by which a "facilitator" provides physical and other supports in an attempt to assist a person with a significant communication disability to point to pictures, objects, printed letters and words, or to a keyboard. Personal accounts and qualitative descriptions suggest that messages produced using this technique may reveal previously undetected literacy and communication skills in people with autism, and other disabilities. When information available to facilitators is controlled and objective evaluation methods are used, peer-reviewed studies and clinical assessments find no conclusive evidence that facilitated messages can be reliably attributed to people with disabilities. Rather, most messages originate with the facilitator. Moreover, Facilitated Communication may have negative consequences if it precludes the use of effective and appropriate treatment, supplants other forms of communication, and/or leads to false or unsubstantiated allegations of abuse or mistreatment.

It is the position of the American Speech-Language-Hearing Association (ASHA) that the scientific validity and reliability of Facilitated Communication have not been demonstrated to date. Information obtained through or based on Facilitated Communication should not form the sole basis for making any diagnostic or treatment decisions.

ASHA strongly supports continued research and clinical efforts to develop scientifically valid methods for developing or enhancing the independent communication and literacy skills of people with disabilities.

Speech-language pathologists are autonomous professionals who are responsible for critically evaluating all treatment techniques in order to hold paramount the welfare of persons served in accordance with the ASHA Code of Ethics. Speech-language pathologists should inform prospective clients and their families or guardians that currently the scientific validity and reliability of Facilitated Communication have not been established, and should obtain their informed consent before using the technique.

Reference this material as follows:
American Speech-Language-Hearing Association, (1995, March). Position Statement Facilitated Communication. *Asha*, *37* (Suppl. 14, pp. 22).

Defining Features, Continuing Controversies, and Recommended Practices Associated with Facilitated Communication

Draft to be submitted to Language, Speech and Hearing Services in Schools

Please do not quote

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Disagreements about Facilitated Communication (FC) have pervaded virtually all aspects of its use. People argue about what it is, whether is should be used, who could benefit from its use, who have benefited from its use, how existing research results should be interpreted, and what research is needed to determine its efficacy. One thing the parties involved in the debates seem to agree on is the need for professional organizations to offer its members guidance in how to respond to the controversies associated with facilitated communication.

ASHA has recently responded to this need by developing guidelines outlining recommended practices in Facilitated Communication (Appendix A). The enclosed FC Guidelines were developed over a period of three years by a Joint Study Section on Facilitated Communication, appointed by two of ASHA's Special Interest Divisions: Division 1, Language Learning and Education, and Division 12, Augmentative and Alternative Communication.

ASHA's FC Guidelines do not offer definitive solutions to the controversies surrounding FC. Nor do they draw conclusions about efficacy of FC. Rather, they: (1) suggest ways for professionals to tie FC practices to other, more established professional practices, (2) indicate what professionals might include in their informed consent practices when prescribing FC, (3) recommend ways to monitor a client's successes or failures with FC, (4) outline some clinical competencies for potential facilitators; (5) and offer ways of responding to actionable statements if made via FC.

In this, the first of three forum articles about ASHA's FC guidelines, I outline features of FC, as presented in the early descriptions by Crossley (Crossley & McDonald, 1980) and Biklen (1990) and additions to early practices that have evolved over the past 10 years. I then present some of the issues associated with FC, with the aim of determining why it has received such critical attention. I conclude by outlining how the enclosed guidelines address some of the controversies and how recommendations in the guidelines might be extended to other clinical approaches carried out by Speech-Language Pathologists.

My article is followed in this forum by another two articles on cautionary practices related to FC. The article by Steve Calculator asks that cautions be exerted when theorizing about FC, when selecting FC for use with particular clients, and when evaluating the efficacy of the approach. Rae Sonnenmeier and her colleagues discuss practices related to school inclusion and the potential use of the FC guidelines in school settings.

The authors of all three forum articles were members of the Joint Study Section on Facilitated Communication that was appointed by Divisions 1 and 12 to develop the guidelines. The group has worked together since 1995 following ASHA's passing of a position statement about FC. The guidelines have been reviewed by the steering committees of Divisions 1 and 12, the Board of Division Coordinators, four panels of peer reviewers selected by the Divisions' steering committees, and the full of ASHA's membership. They were approved by ASHA's Executive Board on (date).

1. **What is FC?** Professionals have categorized FC differently, depending upon what they are emphasizing and upon their judgments about the worthiness of the approach. It has been identified as a method for teaching language and literacy (Crossley, 1994; Koppenhaver, Pierce, & Yoder, 1995), as a subset of AAC strategies (ASHA guidelines, Higginbotham, Sonnenmeier, Duchan, 1993); as a technique that can reveal a client's hidden competencies (Biklen, 1990, 1993, Biklen & Cardinal, 1997a, b; Duchan, 1993) and as a potentially damaging, scientifically unvalidated approach (Green, 1994; Jacobson, Mulick, Schwartz, 1995; Shane,1994).

Professionals have also differed in their descriptions of what the method includes. Some have focused on the facilitators' provision of physical support to a communicator (Burgess et al, 1998; Shane, 1994a; Edelson, Rimland, Berger, & Billings, 1998: Wheeler, Jacobson, Paglieri, Schwartz, 1993). Others have described it more broadly, emphasizing not only the physical but

emotional, communicative, and contextual (curricular) support provided by the facilitator (Biklen, 1990, 1993; Duchan, 1993; Haskew & Donnellan, 1992; Schubert, 1992).

The earliest and most disseminated description of FC is that provided by Douglas Biklen, who published his observations of Rosemary Crossley, who originated FC in Australia. Biklen outlined various components of the method, identifying 25 different practices. An abbreviated (and somewhat reorganized) version of Biklen's list is presented in Table 1.

Recent additions to the method have been made, based on the controversies surrounding it and advances based on experience with the approach. Now, best practices in carrying out FC and in-service programs for training new facilitators are likely to include recommendations about a variety of different aspects of FC. These recommendations have focused on client rights to information and choice, identification and control of inappropriate influence from the facilitator, responses to actionable messages, and facilitator training. (See Table 2 for specific recommendations and those who have made them.)

2. **Framing the issues.** Media coverage and the dramatic impact of the method on clients' lives has fostered polarization of positions about FC. Professionals discussing the issues have been cast as FC proponents or detractors. Within this dichotomous frame, participants assume roles of antagonists rather than collaborators. They then see their job as one of defending their position and they take on the goal of winning the debate. The polarizing framework for thinking about FC has required participants on both sides become personally identified with the issues. Members from each camp are placed in a position of defending their position and "winning" others over to their point of view.

The polarization and personalization of FC has diverted attention away from the complexity and importance of the issues surrounding it. The attached guidelines treat FC as complex and multidimensional rather than as along a single dimension (pro vs. con; valid vs. invalid). They also encourage use of collaborative and ongoing approaches to help resolve clinical practice problems rather than require professionals to take a fixed position on the efficacy of the approach.

The guidelines offer approaches for facing several potential concerns when prescribing FC for clients. The overall approach of the guidelines, as depicted in the third column of Table 3, is to regard the resolution of controversies as an inherent part of what needs to be considered when using FC and to assume that the resolutions may be different for different clients. That is, clinicians must work alongside other members of a service delivery team when selecting FC as an AAC approach for particular clients. Team members, including families and the person with the disability, should consider the following: whether the approach is appropriate for particular individuals, what amount and type of physical support might be needed for those selected; what approaches would be appropriate for validating authorship under different circumstances; what AAC strategies might be used to accompany FC and/or to replace FC; how to assure that the communicators' rights of choice and privacy are not being violated.

3. **Extension of guidelines to other clinical approaches**

The existence of practice guidelines for FC imply that they are only applicable to FC. I suggest that we ask ourselves the question about whether it would be appropriate to extend the practices outlined in the guidelines to all clinical practice. I would also suggest that the answer to this question is partially yes. It would be an improvement if, for example, we were as careful in our documentation and respectful of our clients as is recommended in the ASHA guidelines on FC.

But there are aspects of the practices recommended for FC that should not be generalized. We should only use caution when it is warranted. We need not obtain informed consent for each of our clinical approaches. Nor do we need to make sure that every sentence created via FC be examined for facilitator influence. If we become too cautionary, we begin to run counter to best

practices. Cautionary practices that become prohibitive because of the time and energy required and because of the unnecessary suspicions they engender do not serve their intended purpose.

The accompanying guidelines were tailored to the issues raised by those involved in the clinical practice of Facilitated Communication and designed to offer protection to those using FC. It is crucial that the practices not deprive anyone of their right to receive "treatment to communicate messages in whatever modes and as effectively and efficiently as their specific abilities will allow" (National Joint Committee, 1992). It is up to individual clinicians to use the guidelines to protect and encourage communication rather than prohibit it. In that way cautionary practices can foster rather than inhibit the our service delivery to those whose lives depend upon it.

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Table 2. Cautionary practices added to the original set of practices included in Facilitated Communication Training

1 Obtain written informed consent from family members and potential FC candidates	ASHA position statement, 1994; ASHA guidelines, 1998 draft
2. Document the amount and kinds of support provided and strategies used	ASHA technical report, ASHA guidelines, 1998 draft; Biklen, Saha Kliewer, 1995 Sheehan & Matuozzi, 1996; Sonnenmeier & McSheehan, unpub
3. Combine FC with other AAC strategies	Higginbotham, Sonnenmeier, & Duchan, 1993
4. Minimize the amount of physical support provided	Karp, 1993
5. Validate communicators' performance	Cardinal, Hanson, & Wakeman, 1996; Shane, 1994a, Wheeler, et al, 1993
6. Indentify and reduce facilitator influence	Burgess et al, 1998; Kezuka, 1997; Perry, Bryson,& Bebko, 1998
7. Inform clients and families about current research on FC	ASHA technical report, 1994; ASHA position statement, 1995
8. Respond appropriately and sensitively to actionable messages communicated via FC	ASHA guidelines, 1998 draft Morton, 1992 Pennsylvania Guidelines, 1994
9. Obtain state-of-the-art training in FC and AAC	ASHA tech report, 1994 ASHA guidelines, 1998 draft
10. Provide services for FC using a team approach	ASHA guidelines, 1998 draft
11. Use multiple sources of information when making recommendations based on FC information	ASHA tech report ASHA guidelines, draft, 1998

TABLE 3. Controversies and Positions			
Controversy	**Extreme Pro FC Position**	**Extreme Con FC Position**	**ASHA Guidelines Position**
Selection of FC	FC should be tried with all individuals who have severe communication problems.	FC should not be used unless all other AAC methods have failed.	FC should be used with those who cannot point reliably and /or those who have had difficulty accessing communication systems with other AAC strategies.
Role of physical touch	Physical resistance provides physical and psychological focus allowing communicator self control during message production	Physical guidance results in facilitators influencing movement of communicator during message production	Physical touch should be minimized, facilitators should actively control influence, facilitators and communicators should actively work toward achieving physical independence
Assessing and validating the success of individuals' use of the method or of the method in general	Natural approaches with minimal interference should be used, not highly controlled tasks. Validation is evidenced when communicator provides unpredictable information that facilitator could not have known.	Controlled (experimental) tasks in which communicator is required to provide information unknown to the facilitator should be used to validate the method for a particular client, not qualitative or anecdotal information which cannot control for facilitator influence.	Performance should be well documented, using anecdotes, performance checklists, transcripts, interviews, consumer surveys, blind and double blind procedures. Validation of actionable statements (e.g., reports of abuse, requests for life changes) should be done using multiple facilitators, alternative AAC approaches. Assessment and validation of the success of FC should be done over time and not based on a one-shot performance.
Uniqueness of approach	FC is a natural outgrowth of AAC, FC is a type of AAC.	FC is unique and should not be considered part of AAC.	FC is an AAC strategy and is compatible with other strategies used in AAC. Individuals should have access to all types of AAC strategies, not just those associated with FC.
Rights of communicators	Communicators have the right to receive all approaches of communicative support and the right to choose FC.	Communicators have the right to author their own messages and FC is a violation of this right.	Candidates for FC and their families should be provided information about the method , its benefits and risks, and the issues surrounding it. Service delivery teams should obtain informed consent from participants prior to the use of FC. Candidates have the right to choose to use or not to use FC . Their messages should be kept confidential unless they provide permission to have their messages disseminated to others.